

# Medical History

*It is very important that I know your medical and dental history. An accurate and current history is essential to provide you with the safest, most appropriate treatment indicated for your specific situation. If there are any questions which you do not understand, just circle the question and the doctor will clarify that item at the exam. This information is strictly confidential and will not be released unless your consent is given in writing.  
Thank you for taking the time to completely and accurately answer this questionnaire.*

Your estimated current physical health is:  Good  Fair  Poor Are you currently under the care of any physician?  Yes  No

Physician's name: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone No.: \_\_\_\_\_

When did you last consult a physician? \_\_\_\_\_ Reason: \_\_\_\_\_

Have you been a patient in a hospital in the past 6 years?  Yes  No Reason: \_\_\_\_\_

Have you ever had any serious illness or operations?  Yes  No Describe: \_\_\_\_\_

Are you taking any medications, or pills either prescription or over-the-counter? Please list, \_\_\_\_\_

Do you have, or have you had any of the following?

1. Hip replacement, Artificial Joints .....  Yes  No

a. If yes, Location: \_\_\_\_\_ Type: \_\_\_\_\_

b. How long after transplant: \_\_\_\_\_

c. Any problems associated with the joint .....  Yes  No

Ex.: replacement, infections, hematoma

2. Immunosuppressed by either a drug or a disease..  Yes  No

Ex.: Systematic Lupus, Chemotherapy, Aplastic Anemia, HIV

3. Heart Disease

a. Need to be pre-medicated with antibiotics before dental treatment .....  Yes  No

Reason: \_\_\_\_\_

b. Artificial valve Replacement .....  Yes  No

c. History of Bacterial Endocarditis .....  Yes  No

d. Congenital Heart Disease.....  Yes  No

Ex.: • unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits

• a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure

• any repaired congenital heart defect with residual defect at the site adjacent to the site of a prosthetic patch or a prosthetic device.

e. Cardiac transplant that develops a problem in a heart valve.....  Yes  No

f. High Blood Pressure.....  Yes  No

g. Myocardial Infection, Heart Attack .....  Yes  No

h. Pacemaker, Heart Surgery.....  Yes  No

i. Stroke .....  Yes  No

4. Blood Disorder:

a. Anemia, Bleeding Problem .....  Yes  No

b. Hemophilia.....  Yes  No

c. Blood Transfusion .....  Yes  No

5. Arthritis.....  Yes  No

6. Seizures, Epilepsy, Fainting .....  Yes  No

7. Tumor History, Cancer .....  Yes  No

8. Chemotherapy, Radiation Treatment.....  Yes  No

9. Sinus Trouble/Infections .....  Yes  No

10. Psychiatric Treatment .....  Yes  No

11. Glaucoma/Cataracts/Loss of Sight .....  Yes  No

12. Earaches, Ringing in Ears, Loss of Hearing.....  Yes  No

13. Osteoporosis/Osteopia

a. Have you ever taken oral bisphosphonate such as (Actonel, Fosamax, Boniva, Shield, Dedronel)...  Yes  No

14. Have you ever taken IV bisphosphonate such as (Zomete, Aredic, Benefos) .....  Yes  No

15. Thyroid Disease: (Hypothyroid, Hyperthyroid) ..  Yes  No

16. Diabetes, If yes, date diagnosed \_\_\_\_\_  Yes  No

17. Kidney Disease .....  Yes  No

18. Ulcers.....  Yes  No

19. Hepatitis, Liver Disease, Jaundice .....  Yes  No

20. Venereal Disease, Syphilis, Gonorrhea, Herpes.  Yes  No

21. HIV+, A.R.C., A.I.D.S.....  Yes  No

22. Asthma, Emphysema, Bronchitis .....  Yes  No

23. Tuberculosis.....  Yes  No

24. Chemical Dependency, Alcohol, Drug use.....  Yes  No

25. Cigarette, Snuff.....  Yes  No

a. Duration \_\_\_\_\_ Quantity \_\_\_\_\_

24. Have you taken within the last 12 months:

a. Cortisone, Steroids .....  Yes  No

b. Anticoagulants, Blood Thinners .....  Yes  No

25. Allergies (Please circle)

a. Penicillin, Erythromycin, Cephalosporins .....  Yes  No

b. Tetracycline .....  Yes  No

c. Other Antibiotics .....  Yes  No

d. Codeine .....  Yes  No

e. Aspirin .....  Yes  No

f. Sleeping Pills .....  Yes  No

g. Dental Anesthetics.....  Yes  No

h. Other .....  Yes  No

Women

1. Regular Menstrual Cycle .....  Yes  No

2. Are You Pregnant .....  Yes  No

3. Are You Taking Birth Control Medication.....  Yes  No

4. Are You Taking Hormone Supplements.....  Yes  No

(Continued on back)

# Dental History

Present Dental Complaint? \_\_\_\_\_

Have you experienced any unfavorable reaction to previous dental treatment? Describe \_\_\_\_\_

Who is your regular dentist? \_\_\_\_\_ For how long? \_\_\_\_\_

When did you last have any dental work? \_\_\_\_\_ What was done? \_\_\_\_\_

When were your teeth last cleaned? \_\_\_\_\_ How long before that? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

Are you using any other dental cleaning aids? If so, what? \_\_\_\_\_

Are you experiencing any pain in your mouth. Where? \_\_\_\_\_  Yes  No

Are your teeth sensitive.....  Yes  No

Are any of your teeth loose .....  Yes  No

Do you have any unpleasant taste or odor in your mouth.....  Yes  No

Do your gums bleed? If yes, when? \_\_\_\_\_  Yes  No

Do you grind or clench your teeth .....  Yes  No

Have you noticed increasing spaces between teeth? If yes, when? \_\_\_\_\_  Yes  No

Are your gums receding.....  Yes  No

Are you missing teeth? Reasons: Cavities ( ) Gum Disease ( ) Trauma ( ).....  Yes  No

Were missing teeth replaced.....  Yes  No

Are you satisfied with the appearance of your teeth .....  Yes  No

Has periodontal disease been found in your mouth before? If yes, when? \_\_\_\_\_  Yes  No

Have you ever had periodontal treatment? If yes, when? \_\_\_\_\_  Yes  No

Have you ever had orthodontic treatment (braces) .....  Yes  No

Are you seeing a doctor for DENTAL IMPLANTS.....  Yes  No

Do you presently wear full dentures? Upper ( ) Lower ( ) .....  Yes  No

Do you presently wear removable partial dentures? Upper ( ) Lower ( ).....  Yes  No

Are you interested in replacing your denture or partial with implants.....  Yes  No

Why are you dissatisfied with your present appliances:

\_\_\_ The inconvenience \_\_\_ The appearance \_\_\_ Inability to chew \_\_\_ Painful \_\_\_ Other

Do you presently have missing teeth that have not been replaced .....  Yes  No

## Treatment Authorization and Informed Consent

*I consent to examination as necessary or desirable to care of the registered patient, for the diagnosis of dental disease, deformity, or treatment or dental emergency. The procedures may include radiographs, models, photographs and intra-oral exam. In case of a dental emergency, I consent to emergency treatment as deemed necessary by the doctor, understanding that procedures will be explained in advance. I have read and completed this questionnaire to the best of my knowledge and agree to the above policy.*

\_\_\_\_\_  
Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Periodontist

\_\_\_\_\_  
Date